

Exemplars from Practice

A Collection of Work

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Introduction

As part of the year one professional practice papers at Christchurch Polytechnic, within the Bachelor of Nursing programme, students are required to reflect on their practice. At the end of the year they are asked to write a summative assignment applying the competencies within the helping role, as identified by Benner (1984), to their practice. This is in the form of exemplars based on their personal journal entries from throughout the year. As part of this assignment they are asked to describe their insights and reflections on their experiences.

This publication presents a series of eleven pieces of student work covering the following domains of practice identified within the helping role (Benner, 1984, p. 50):

- Providing comfort measures and preserving personhood in the face of pain and extreme breakdown.
- Presencing: Being with a patient.
- Maximising the patient's participation and control in his or her own recovery.
- Interpreting kinds of pain and selecting appropriate strategies for pain management and control.
- Providing comfort and communication through touch.
- Providing emotional and informational support to patients' families.
- Guiding a patient through emotional and developmental change: Providing new options, closing off old ones: channeling, teaching, mediating.

It is our intention that these pieces of student work will become a valuable resource for other year one students as well as providing insightful reading to the wider nursing community.

We believe reflection on practice, combined with the field of gerontological nursing is paramount for the profession's future growth and development. The Gerontology Association wishes to promote excellence within nursing the older person and has provided a scholarship for each group of year one students. The John Murphy Memorial Scholarship is awarded by the association for the most outstanding "Benner assignment". All assignments within this collection of work have been put forward for consideration for this scholarship.

A special thanks is given to the students who have allowed their work to be presented in this publication.

Happy reading.

Kaye Milligan, Stephen Neville

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Benner Assignment 1 by Tracey Bond

As student nurses we are repeatedly being encouraged to journal about events that stand out in our nursing practice, at clinical placement. Many of us feel that this is an extra task designed to load us down with more work that seems practically pointless. For me the importance of journalling has been highlighted as I near the end of my first year as a student nurse. As I read my early attempts at journalling I am amazed at the progress I've made. At times I feel as though I have learned so little, yet by reflecting on previous journal entries I am encouraged by my development as a future Registered Nurse.

Nursing in the past has been characterised as being very oral, shared only between colleagues. As a result much information and experience has been lost or unrecognised. Patricia Benner is one of a growing number who have recognised the need for nursing to become more literate, stating "The linear ideal that theory must be generated first and then applied to nursing has given us a deficit view of nursing practice, allowing us to see only the gaps" (Benner, 1984). These "gaps" can only be filled if we as future nursing professionals begin documenting our experiences and knowledge.

Benner (1984) identified seven domains of nursing practice:

- The helping role.
- The teaching-coaching function.
- The diagnostic and monitoring function.
- Effective management of rapidly changing situations.
- Administering and monitoring therapeutic interventions and regimens.
- Monitoring and ensuring the quality of health care practices.
- Organisational and work-role competencies.

This assignment will focus on the first domain: The Helping Role.

Patricia Benner (1984) based her theory on narratives of nurses related to episodes of patient care. Using as much detail as possible, the nurses were asked to describe their intentions and interpretations of what happened and also outcomes of their actions.

The Helping Role

Helping is probably the most visible role of the nurse. But in fact much of the help given by nurses is subtle and not obvious to most. Benner (1984) states that you can receive help without asking for it and even if you do ask for it you may not receive it.

The helping role can be broken down into eight competencies which emerged from the analysis of the observations and interviews (Benner, 1984):

- The healing relationship: Creating a climate for and establishing a commitment to healing.
- Providing comfort measures and preserving personhood in the face of pain and extreme breakdown.
- Presencing: Being with a patient.
- Maximising the patient's participation and control in his or her own recovery.
- Interpreting kinds of pain and selecting appropriate strategies for pain management and control.
- Providing comfort and communication through touch.
- Providing emotional and informational support to patients' families.
- Guiding patients through emotional and developmental change: Providing new options, closing off old ones: Channelling, teaching, mediating.

Working with clients in a hospital environment, where many suffer from various forms of dementia and have limited verbal communication abilities has been the major challenge for me this year. The following exemplar is an indication of my initial response to a client suffering from Alzheimers Disease and as a result has severe dementia.

14 August 1996

With eager anticipation I sought out the client I had been assigned to spend a significant period of time with during the time I am in clinical. Soon it will be my responsibility to meet her daily needs once a week.

As I looked at Mrs B my heart sank. This woman seemed almost incapable of communicating with me. Hopeful - I chatted to Mrs B, without getting an intelligible answer...

I remember the feeling of hopelessness that filled me when I first met Mrs B. I think I was actually scared of her. I didn't know how to communicate with someone who couldn't speak to me.

This contrasts with my practice later on with the same client.

11 September 1996

I felt quite frustrated at clinical today. I feel as though I should be doing more for Mrs B. She is such a lovely person that I wish I could make life a little more stimulating. She is so isolated from her family, friends, church and culture. Although I have no way of knowing how much value she placed on any of these areas, I do recognise that she led a very full life and this needs to be recognised.

As nursing students we are constantly being taught the importance of holism and it is this concept that I strive to achieve more. I feel that I am meeting Mrs B's physical needs but not her spiritual, cultural or emotional needs.

Although Mrs B has limited vocal communication it is important to realise that speaking is only a small part of communication and body language, facial expressions and even non-word sounds are important tools and can be used to determine her needs. This will hopefully occur as the rapport between us grows. I believe this is an example of the presencing component of the helping role. By simply spending time with Mrs B and being aware of both her limitations and abilities I was able to develop a therapeutic relationship. By simply being there I believe it was possible to create an atmosphere where Mrs B. was able to display her feelings and frustrations. By presencing I was able to see the need to develop the care I was giving to achieve a greater level of comfort.

Because of the learning I was able to do with my primary client, this experience and knowledge has enabled me to be more aware with clients I have had little or no previous contact with. An example of this is given in the following exemplar.

22 November 1996

As we turned Miss M onto her side she began to cry. She hid her face in her hands but I could hear her sobs. I asked her what was the matter. "I don't know where I am" she repeated over and over getting more and more upset.

My heart sank. I had heard this before, and I wondered if she really wanted to know, so I didn't say anything. I sat by her bed and held her hand. After about five minutes she stopped crying and just laid there staring at me. I didn't feel as though I needed to say anything, the silence was not uncomfortable. After a time, Miss M said that she wished Jessie was here. Although I didn't know who Jessie was, I understood her need to be with someone she loved. She didn't seem unhappy now and soon fell asleep.

I feel this exemplar shows my practice in the presencing role, being with a patient. I was able to provide comfort and a sense of being important just by being with Miss M and by not speaking I didn't judge or scold her. I did my best to provide comfort to a woman who was obviously distressed by allowing her to express her sadness and also perhaps anger and acknowledge these feelings simply by being there and listening. Although I had spent little time with Miss M previously, I felt very close to her at that time and made an effort to visit whenever I had a spare moment. By simply holding her hand I allowed her to know that I was there more effectively than by speaking to her. I now feel more confident about doing what is most appropriate for a particular situation and recognise the importance of non-verbal communication.

This is also an example of providing comfort and communication through touch. By holding Miss M's hand I believe I made her feel valuable and listened to. "Touch conveys relational and support messages as well as physical stimulation and comfort. It is perhaps symbolic of the direct laying on of hands, so central to nursing care" (Benner, 1984, p. 64).

In an environment where many of the clients are so isolated from family and friends, touch by another human may be limited to daily cares. From my experiences in clinical, I believe that touch is important for most and should be an important part of any therapeutic programme where appropriate.

The value of journalling has been highlighted by this assignment. It is so obvious how much would be lost without recording the feelings as well as events as your time in clinical progresses. As I read over my year at clinical I am surprised at the progress I've made. There have been times when I have doubted my abilities and questioned my judgement. Journalling these experiences has enabled me to reflect and share with others my worries and doubts, often to discover that they are shared by my colleagues. Probably most importantly, journalling has also enabled me to realise that even though a person may be limited in their abilities to communicate and their mobility may be reduced, they are important human beings who have the same basic feelings and needs as every other living person. The care of the aged is a challenging often

daunting or even scary but truly rewarding experience. In a society that values youth, it is often forgotten that the aged have so much to give and as nursing professionals I believe it is vital that we acknowledge this wealth and foster a more positive attitude about a highly discriminated and often neglected group.

Reference

Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing practice. California: Addison-Wesley.

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Benner Assignment 2 by Michelle Turner

Patricia Benner in her book "From Novice To Expert" (1984) says that nurses have many different roles in their nursing practice. She says there are seven different roles. In this essay I am going to look at Benner's (1984) "Helping role". This role is made up of nine different competencies, but in this essay I am only going to look in detail at the "presencing" and "providing comfort measures and preserving personhood in the face of pain and extreme breakdown" competencies. I will then present exemplars showing experiences I have had whilst nursing the older adult. These exemplars will show an advancement in my nursing practice in the areas of presencing and providing comfort measures. I will reflect on these exemplars and indicate how the experiences in my exemplars have contributed to an advancement in my nursing practice.

The nine competencies making up Benner's "Helping role" are as follows; presencing, providing comfort measures and preserving personhood in the face of pain and extreme breakdown, using goals therapeutically, building and maintaining a therapeutic community, maximizing the patient's participation and control in his or her own recovery, interpreting kinds of pain and selecting appropriate strategies for pain management and control, providing emotional and informational support to patients' families, guiding patients through emotional and developmental change, and psychological and cultural mediation (Benner, 1984). In this essay I will look at only two competencies, as mentioned above.

According to Benner (1984) many nurses are taught that they are doing their job best when they are "doing for a patient". However Benner (1984) states that many nurses through their practice realise that often just being with a patient is the best and most important thing you can do.

According to Benner (1984) presencing is part of helping and to be able to presence yourself with your patient you have to have self-esteem and self-confidence to see the value of your presence for your patient.

Often presencing involves touch and person-to-person contact between patient and nurse. It also involves allowing the patient to ventilate their feelings (Benner, 1984).

Benner (1984) talks about nurses going from novices to experts in their helping role as they become more experienced. As students we all generally begin in the novice stage when presencing which is evident in my behaviour demonstrated in my first exemplar. A situation arose where a person who was a patient in our ward needed someone to be present with her and I was of little assistance due to being a novice with the presencing aspect of helping.

12/10/95 EXEMPLAR ONE

When I walked into Mrs X's room she looked pale, distressed and as though she was in pain. She looked as though she had lost some weight since I had last seen her a few weeks ago when she had come into our ward having had a colostomy.

Nurse W and I lifted Mrs X up onto the pan and Mrs X grimaced and made a light groaning sound. She was in pain. Not only was she in pain, but her colostomy bag clip had unclipped and loose faecal matter had escaped. Faeces was on her jersey, shirt, trousers, and bed as well as in her white hair.

I felt too embarrassed to tell Mrs X so I told nurse W as she hadn't seen what had happened and I didn't want to leave Mrs X as she was. Nurse W told Mrs X what had happened and she started to cry.

She said "I'm fed up with all this". Taking her glasses off to wipe her tears away she said again "I've almost had enough of this".

I felt bad for her, but didn't feel I had much I could do or say to her. I felt awkward and looked to nurse W for help. I avoided Mrs X but cleaned her up whilst nurse W held her hand and talked to her as she cried. I felt hot, sweaty and embarrassed. I tried not to look at this lady or nurse W as I thought they would see my incompetence and anxiousness. I saw Mrs X brighten up as nurse W talked and listened to her. It felt good to see her happier.

As I walked down the hospital corridor I felt as though I had wanted to help this lady but hadn't, as I thought she wouldn't want my help as I was a student nurse and what would I have said to her anyway? As I emptied Mrs X's bed pan I decided I wanted to be a good nurse like nurse W had been in this situation. I decided I would put more effort into helping next time this kind of situation arose.

This exemplar shows how as a nursing student I was a novice with presencing. I had wanted to do more, but didn't have the self-esteem and self-confidence to see the value of my presence for this patient. At the time of this situation I felt uncomfortable and so coped by "doing" for her as Benner (1984) mentions.

Having experienced few situations like this one I felt of no value to this lady. I had felt as though I couldn't

help her and as though she wouldn't have wanted my help anyway. Through further experiences similar to this one I have learnt to read situations and cope better with presencing.

Benner (1984) mentions that with experience nurses progress from being novices to advanced beginners. This can be seen in my practice as shown in my next exemplar where I have become more able to read situations and see when my presence is valued.

30/11/95 EXEMPLAR TWO

I was showering 73 year old Mrs G, who had recently suffered from a right cerebrovascular accident. We talked about the heart attack she had had a year ago and then Mrs G began to talk about her recent cerebrovascular accident. She seemed sad as she talked and I felt as though she really wanted to "let things off her chest".

She recalled how the C.V.A had happened. She started to cry as she talked about how she had woken up one morning and she couldn't move, speak or do anything. She said all she could do was roll her eyes.

I turned the shower off and wrapped some towels around Mrs G. I held her hand as she continued to talk about how she had a fear of what was going to happen to her and how no-one understood or listened to how she felt. She kept saying she was sorry and I could tell she was embarrassed. I asked her if she wanted to talk some more and she carried on talking and crying whilst I held her hand and listened.

Mrs G talked about her fear of "being stuck in hospital". Finally she came to the conclusion that we don't know what the future holds so therefore she would just have to try her best to rehabilitate as nothing else could be done. Mrs G wiped her tears and said she felt better. She said "thank-you" to me and I felt slightly embarrassed, but happy that I'd been there for this lady.

This exemplar shows a great deal of growth and development since my experience in exemplar one.

In this exemplar I am an advanced beginner with presencing. I read the situation well and had empathy with this lady.

I wanted to help this lady and through previously facing a number of experiences similar to this one I had developed the self-confidence and self-esteem to help this lady. I could see the value of my presencing for this patient so listened and had empathy for Mrs G.

I was able to encourage her to come to her own conclusions about her problems and I left her happy, content and positive about her rehabilitation. I am glad I was able to listen, support and comfort this lady. I felt privileged to be able to help her. I had been able to do something very simple which many people in the hospital and Mrs G's family had not done and that was to just listen.

Both experiences mentioned in exemplars one and two have contributed to an advance in my nursing practice. Exemplar one encouraged me. Through watching the nurse presencing I was encouraged. I was impressed with the way she coped with the situation so calmly and I liked the way she helped. This experience prompted me to try harder next time I had the opportunity to be present with a patient. As a result of watching this nurse my nursing practice advanced as I was inspired to help the way she had. From this experience onwards I became more confident with presencing as I decided to become more involved with it rather than run from it.

My second experience contributed to an advance in my nursing practice as it had been a very successful experience for both my patient and me. As a result of its success it confirmed to me that I am good at presencing. This experience showed me I am very able at presencing and have good skills to presence with. As a result my nursing practice has advanced as I now take every opportunity to be present with someone as I realise I can help.

Experience two also taught me to make time to listen to my patients. The nurses had been too busy to listen to Mrs G and she had bottled up her feelings. This stressed to me the importance of looking after a person holistically as all too often nurses are busy and look at the illness and not the emotional side of a patient's well-being.

According to Benner (1984) another aspect of helping is shown by a nurse when she/he provides comfort measures and preserves personhood in the face of pain and extreme breakdown. This involves the nurse enhancing the quality of life for the patient when they are ill or unwell. It involves the nurse finding ways to provide comfort for her/his patient. The nurse attends to the patient's personhood and facilitates the patient's sense of personhood, meaning and dignity (Benner, 1984).

The following exemplar shows how as a student I acted as a novice when providing comfort measures and preserving my patient's personhood when she was unwell.

3/8/95 EXEMPLAR THREE

My buddy nurse left me to make our patient comfortable. I washed her and felt awkward when she mumbled to me as I couldn't understand her. I thought about talking to her but decided that was silly and I would have felt weird talking to her when she couldn't talk back.

I felt really rushed as I was needed for a lift by another student. So I washed Mrs M quickly and looked

through her cupboard for a clean nightie. I combed her hair, put her in a clean nightie and wondered if she would like her glasses or hearing aid put in, or some perfume. I decided not to do anything more for this lady as she was unwell and I had to get on with my other work with people who were in better health and who would be able to tell me how I could help them. I didn't really know how to make this lady at ease. She kept mumbling and I couldn't ask her what she wanted so I just made sure she was clean and safe, and then left to help another student.

This exemplar shows how as a novice I was unable to see that this lady would have benefited from me facilitating her sense of personhood, meaning and dignity.

I thought that because this lady was ill she didn't really need things that she would normally have, such as perfume and her hearing aid. I didn't really think about the patient's normalcy. I thought that as long as she was clean and safe that's all I could do for her. I saw some things that I could have done for her, but pushed them aside in a rush as I thought about the other patients who were in better health than this lady and who I thought I could probably do more for.

As this was the first experience I had had with an ill person I think I did well to leave her clean and safe. As I was a novice I didn't really read into the situation and see the many more things I could have done to make this lady comfortable and to facilitate her sense of personhood, meaning and dignity. After this experience I worked with other nurses as much as possible when caring for ill people. They taught me a lot and I soon became comfortable with nursing unwell people.

This next exemplar shows how with having been involved with many more ill people I developed confidence and hence my nursing practice advanced. In this next exemplar it can be seen that I have gone from a novice (as in exemplar one) to an advanced beginner in the area of providing comfort measures and preserving personhood in the face of pain and extreme breakdown.

16/11/95 EXEMPLAR FOUR

I felt scared when I met Mr W as he was unable to talk, open his eyes or move. He had low blood pressure which fatigued him. I talked to him in quiet tones and every now and then his legs would twitch. I asked him if he would like a bath, shower or wash and as he couldn't communicate this was rather pointless. I suppose I still asked him anyway to let him feel I was involving him in what I was going to do for him.

I decided to give him a wash. At first I thought what am I going to say to this man? I thought I'd feel silly if he didn't speak back to me, but then thought that it was better to communicate with him than not say anything at all to him leaving him feeling awkward (even though I couldn't tell if he felt this way or not).

I covered him up for privacy. I washed his face and hands first and then the rest of his body. I rubbed B.K lotion into his cracked heels and pressure points on his buttocks. I brushed his teeth last. I picked out some nice clothes which I thought he would have chosen if he could communicate. I dressed him and he lay on his bed very silently. I combed his hair gently. I found a blade razor in his toilet bag, soaped up his face and shaved away his many prickly whiskers. I stood back and looked at Mr W and thought about what else I could do for him. He still had some whiskers and soap on his face so I washed his face again with a warm face cloth. I then splashed some aftershave on his wrinkled neck.

I looked at him lying peacefully on his bed with his quilt over his legs. He was smiling. He looked nicely groomed and clean. I felt good at what I had done for him. I had made him comfortable and he looked peaceful and at ease.

Later in the day Mr W looked slightly better. As I lifted him up the bed, he held onto my hand and wouldn't let go. He held on for about two minutes. I don't know if he remembered my voice from the morning (when he couldn't open his eyes), but I felt that maybe he recognised my tone, mannerism and kindness from the morning and that he felt secure holding on to me.

This exemplar shows that I was very much involved with providing comfort for this unwell man. I had developed enough confidence and knowledge from other nurses to be able to help this man on my own accord. I read the situation well and although I felt slightly awkward at times I still continued to fulfil my goal which was to maintain this man's dignity and to make him as comfortable as possible.

This exemplar shows I was, during this situation, acting as Benner (1984) would say as an advanced beginner in the area of providing comfort measures and preserving personhood in the face of pain or extreme breakdown. I feel happy that I left this man comfortable and that I did my very best to respect his privacy and make him feel at ease. I know he appreciated what I did for him. I'm sure the smile and the wanting to hold my hand are signs that he was wanting to thank me and that he enjoyed the care I gave him.

This experience contributed to an advancement in my nursing practice in a number of ways. Through this experience I have become more conscious of the little things that I can do for a person when they are unwell. I now realise that every little comfort measure you do for someone is beneficial to how they feel. Now I look more often for situations where I may be able to help someone by doing a small action that will mean a lot to them.

The experience in exemplar four has contributed to an advance in my nursing practice in that I now realise that patients who seem to be semiconscious may be able to still hear you. I now talk to all my patients

whether they respond or not, and also realise the importance of not talking about or over your patient as they may be able to hear you.

By talking to patients who are unwell and seem as though they don't comprehend, I am showing them respect. Through speech I am showing them that I recognise that they are still people with meaning and dignity. I've also learnt that it is good to explain to your patient what you are doing even if they don't seem to respond. They may not be able to hear you but if they can they will be involved and respected.

Conclusion

In conclusion it would have to be said that "presencing" and "providing comfort measures in the face of pain and extreme breakdown" are two very important competencies of the helping role. Through reflecting upon my exemplars it is apparent that through my clinical practice with the older adult I have been involved with many valuable experiences which have contributed to an advancement in my nursing practice.

The experiences that I have faced have helped me to develop greater confidence and so as a result my practice in the clinical setting has improved as shown by the improvement seen in my exemplars. In the areas of "presencing" and "providing comfort measures" I have become more knowledgeable and the care I give in these areas has improved. I have gone from a novice to an advanced beginner in these competencies of the helping role. I hope through more experience that my practice within Benner's (1984) helping role continues to develop providing my patients with the best care I can give.

Reference

Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing practice. California: Addison-Wesley.

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Benner Assignment 3 by Lisa Broughton

"Everyday you carry out an enormous number of activities which, to you often seem ordinary and just part of the job. To your patients, though, you may have done something for them that changed their lives." (Darbyshire, 1991, p. 27).

Patricia Benner's book 'From Novice to Expert' (1984), provides insightful research into understanding the nature of nursing. Within the text she examines how nurses mobilise therapeutic nursing care under the domain 'The Helping Role'. In this reflective discussion I aim to relate two of Benner's eight competencies to personal accounts journalled from clinical practice. For each competency I will provide my insight and reflection to highlight the importance of caring in a mechanistic world.

Caring is an adjective associated with nursing. It is an integral aspect of existence, yet it has many connotations and how does one manifest such an attribute? "Caring has emerged as the focus of contemporary nursing" (Rawnsley, 1990, p. 14). Benner's 'Helping Role' competencies incorporate this fundamental dimension of nursing by valuing caring in action.

The first competency that I would like to discuss involves the use of nurses' touch as a therapeutic tool, noting touch as an aspect of caring. *Providing Comfort and Communication Through Touch*. "Nurses frequently use touch to provide comfort ... often human and warm contact is the only avenue of comfort and communication available" (Benner, 1984, p. 63).

Exemplar: 8 May 1997

Student nurse: On arrival to clinical placement I was assigned to care for a new admission, Mrs X. I entered her room, a woman of small stature sat hunched over a large hospital sick bowl. Mrs X presented with acute abdominal and sacral pain related to a fall, although the origin had not yet been identified. Mrs X was pale, her skin was warm and clammy, she was breathless and was in much pain.

As a student nurse I was unsure of how to respond to her agony. She desperately wanted to vomit however she was unable. I was very concerned for this woman. I proceeded to take her vital signs and was astounded to discover her blood pressure was 240/126. I informed the intern and requested additional pain relief as this indicated to me the extent of her discomfort. I spoke gently to her, trying to reassure her that the origin of pain would soon be discovered and that her suffering would shortly ease.

I took Mrs X's hand, as I felt it appropriate to comfort her in this way, verbal communication seemed disruptive somehow. She squeezed my hand in response to my presence, it was unwritten, but she sensed that I cared. Later as the nausea heightened I softly rubbed her back to console her and placed a cool flannel on her forehead as she coped with her ailment. There was little else that I could do to help and I felt it opportune to care in this manner. Caring for a person who was so obviously ill was a new encounter however I believe that my intuition allowed me to deal with this situation by comforting in a therapeutic way where neither nurse nor client needed to verbalize what was happening. When I next encountered Mrs X she thanked me for caring and verbalized, as this was now appropriate, the importance of my comforting presence when she had been unable to ease her discomfort alone.

Reflective Statement:

I believe that touch is a tool that should be used with discretion. It is not predictably appropriate nor does everyone respond to it positively. Communication and support through touch has been practised by nurses for centuries, however the notability of this is relatively new. Touch is becoming more widely utilized in nursing as education on massage, touch and their benefits are considered, it has become increasingly acceptable. With regards to the exemplar above I interpreted my client's need for comfort and human communication. Acting on intuition, I understood her needs at the time and subconsciously connected with her in a manner that was new to me. Helping a person through this type of ordeal is part of the nurse's role, however as it is not easily measurable, recognition for this type of caring communication is often overlooked by other health professionals. On reflection I have come to realize the importance of touch within nursing and how performing the simplest of things for an ill client can make an experience bearable. I have come to understand the relevance of touch within 'The Helping Role' (Benner, 1984) and identify touch as a fundamental aspect in caring. I believe this exemplar to be similar in fashion to some of those accounts written by Benner. I have when describing this exemplar reinforced the importance of touch as an integral aspect in healing and in life as a whole.

The second competency acknowledges an individual's right to independence and notes how nurses help clients control their own destiny. 'Sensing a patient's strength, drive, desire, and ability to improve, and mobilising these forces in the relationship between nurse and the patient' (Benner, 1984, p. 58). This competency is described as *Maximizing the Patient's Participation and Control in His or Her Own Recovery*. I

believe that independence from others encourages self worth, self esteem and provides a reason for existence, with the able bodied person and likewise with the clients that we nurse.

Exemplar: 15 May 1997

Student nurse: My client Mrs Y was 77 years of age and had recently suffered a right CVA and as a result had left sided weakness. Mrs Y had reduced trunk strength, flaccid muscles in her left upper extremity and had poor weight bearing capacity on her affected side, however her positive attitude impressed me. As a student nurse I noted her strength and eagerness to succeed and felt it was important to help her attain her goals.

Mrs Y assisted me as much as she was able, managing her daily activities and I in turn encouraged her as we went. Transferring from her bed to a chair or from one seat to another required a lifting belt and one nurse at this stage. I was positive that Mrs Y could complete this transfer with reduced assistance, however her self confidence appeared low. When she returned from physio this particular morning her confidence had heightened and she transferred with greater ease. I commented on her advancement, noting how I had not used any effort to assist her, yet she replied, "It's your doing not mine". During the day we transferred her a number of times, each time I reduced my physical assistance and used verbal motivation until she realized the extent of her progress.

Mrs Y thanked me for believing in her, for letting her complete the transfers in her own time. I believe this action reinforced her capabilities and encouraged further steps of independence. Three weeks after this initial encounter she could transfer with complete ease, she could lift her left arm and was independent in dressing. I believe that the helpfulness and belief in her, by the nurses who allowed her to take her time, really influenced her healing and I felt honoured to be a part of the process.

Reflective Statement:

Reflecting upon Mrs Y's regaining of her self confidence and her physical strength, there are two aspects that I would like to emphasize. The first is that as busy nurses, it often does not seem feasible to spend time supporting a client in this manner, spending precious time with one client when there is much to be done. However I believe that control of one's own activities is central to one's perception of life, and mobilizing a client's ability to be in command should therefore be considered. If in this circumstance I had not perceived Mrs Y's ambition and had not gradually decreased the use of the lifting belt she could have lost confidence and become more dependent as time progressed. Benner (1984) suggests that patients should be in control of their recovery. However this is not likely to occur if clients are not supported and encouraged to take responsibility for their progression.

A point to consider however is that not everyone wants to be in control, rehabilitation scares some individuals. I believe that an effective nurse/client rapport is essential to encourage the rehabilitation process and the ascent to recovery. Perceiving the positive development no matter how minor could lead a client to respond positively with trust and security needing to be developed initially.

In conclusion 'helping' within nursing reaches further than is imaginable. Each situation needs to be analysed in order to decide how best to aid the client. Helping can become motivating or directing individuals as appears appropriate at the time. I believe that nursing is a profession in which there are many grey areas and whether a nurse decides to enter the grey or remain in the black or white influences people's outcomes.

Caring is expressed daily within nursing however it is necessary that it is refreshed and does not become stagnant. Care received through medical personnel may transform a person's life, and being present to assist in this is a privilege. Sharing positive nursing experiences credits our profession. "Narrative approaches to understanding nursing have become increasingly important ... are a valuable approach to understanding nursing practice ... can trigger what have been called 'paradigm shifts' - those moments when we undergo a deep fundamental change." (Darbyshire, 1991). It encourages, motivates and may transform possibilities for others to learn from, and partake in.

'Helping', therefore is not as simplistic an action as I once assumed and it is not easily defined. However through the research by theorists such as Benner (1984) we can begin to understand the range of what 'helping' involves. The main challenge now is relating and integrating this to practice.

References

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Exemplars from Practice

A Collection of Work

Benner Assignment 4 by Vicky Ryan

Introduction

As defined by Benner (1984) I have chosen three competencies within the helping role and selected journal entries which illustrate my practice within these areas.

For my first exemplar I have chosen Maximizing the Patient's Participation and Control in His or Her own Recovery. "This competency entails at least two components, sensing a patient's strength, drive, desire, and ability to improve, and mobilizing these forces in the relationship between the nurse and the patient" (Benner, 1984, p. 58).

My second exemplar is presencing, being with a patient. "Nurses are often trained to believe that they are most effective when doing for a patient. Several nurses noted, however, the essential importance of just being with a patient" (Benner, 1984, p. 57).

My third exemplar is interpreting kinds of pain and selecting appropriate strategies for pain management and control. "Pain management and control have become more sophisticated and specialised in terms of varying pain control and management procedures to meet particular kinds of pain. Selecting the appropriate strategies at the right time falls into the domain of nursing judgement" (Benner, 1984, p. 59).

I have also included my reflections at the end of each exemplar which describe my feelings and how these experiences have influenced my clinical practice.

Maximizing the patient's participation and control in his or her own recovery (Benner, 1984).

Exemplar 1: 12 March 1997

I arrived at the Resthome at 7.45 am feeling a little apprehensive about my new client. Mrs P, a 96 year old lady, recovering from a broken tibia and fibula, was completely blind and very hard of hearing. After reading Mrs P's daily notes I was made aware that her spirits had been low over the past few days. I entered her room with a cheery good morning and inquired if she would like a bath. Mrs P said she would enjoy a bath and we proceeded to the bathroom.

While assisting Mrs P with her bath, we chatted away and I began to wonder what it would be like to live in a world of darkness. On returning to Mrs P's room, I asked her what she would like to wear. Mrs P told me to select something. It seemed to me that she didn't really care what she wore and she seemed quite disinterested. I browsed through her wardrobe and selected something nice and bright hoping this would cheer her up. As I dressed Mrs P, I explained in detail all the colours in the dress. Mrs P had lost her sight at the age of 34 due to glaucoma but I felt sure that my descriptions would help her to visualise the colours. The dress had a bold pattern with orangy brown, like autumn leaves, bright-blue like the sky, and yellow like the sun. I chose a matching blue cardigan and shoes and told her she looked lovely. Mrs P's face lit up with a smile. She said she could picture how she looked. "No-one has ever bothered to ask me what I would like to wear and certainly never taken the time to explain all the colours the way you have". When I asked her why she thought that was, she said it was probably because she was blind. Mrs P had often wondered what she looked like as it had been many years since she had selected her own clothing.

Reflection

I feel that Mrs P's blindness contributed to her feelings of inadequacy and that her carers in the past may have overlooked certain issues. Mrs P could not visually see the colours but because she was once sighted she still had graphic images of what things looked like. Mrs P had other needs which needed to be addressed, one was her self image, which could have psychological effects and the other was self esteem which had been damaged. I believe that when a person has a permanent disability that many things can be taken for granted. My nursing has taught me to look at my clients holistically, to put myself in their situation and think how I would like to be treated. Although I feel it was a small contribution I made, the results I gained made me happy and certainly lifted Mrs P's spirits.

In the weeks that followed I saw a marked improvement in Mrs P's mood and she always looked forward to my days in clinical.

Presencing: Being with a patient (Benner, 1984).

Exemplar 2: 5 March 1997

Mrs C had been my client for several weeks and I had learnt a great deal about her family and friends. Mrs C's daughter-in-law was a regular visitor to the Resthome and a dear friend. Mrs C spoke of her often and

said that although she was a family member that was not the reason she visited, they had many things in common. When Mrs C's daughter-in-law became ill, Mrs C was very upset and worried. When I arrived in clinical in the morning I was approached by one of the carers, she informed me that Mrs C's daughter-in-law had passed away. I knew Mrs C would be devastated and I was concerned about the effect this would have on her.

I knocked on the door of Mrs C's room and entered. She was sitting in her armchair, her frail body looking so vulnerable. Her eyes were red from crying and I imagined what her pain must be like. I knelt beside her clasping her hands in mine. I felt myself start choking as I tried to offer her my sympathy. Tears began to trickle down her cheeks and I felt tears in my own eyes. It was a very emotional moment, then I instinctively gave her a hug and found she was responsive. I hoped that I had given her some sort of comfort although I had said very little. I was in the room for about 20 minutes and hardly spoke but I knew that Mrs C needed my support and I was able to offer that.

Reflection

I am aware that people have different ways of dealing with grief and death. Often when confronted with death it's hard to know what is right and what is wrong. It was fortunate for me that Mrs C had let me into her personal world with open arms. We had developed a friendship very quickly and easily and she often shared her most intimate thoughts with me. I was not afraid to show her my emotions and she also showed hers, it came quite naturally. I knew I did not have to say a lot to her but just being there was enough.

Benner (1984, p.57) states, "nurses are often trained to believe that they are most effective when doing for a patient. Several nurses noted, however, the essential importance of just being with a patient". The following week Mrs C said she was very grateful for the support I had given her. I wish that I could have done more.

Interpreting kinds of pain and selecting appropriate strategies for pain management and control (Benner, 1984).

Exemplar 3: 16 June 1997 & 17 June 1997

I have been looking after Mr J for a couple of weeks now and he has constantly complained of pain in his knees. I am aware that he has osteo-arthritis in both knees and was due to have surgery when he had a stroke. Mr J has been taking four hourly panadol which has had little or no effect. He has been very distressed by his level of pain and I am sure that this is contributing to his lack of mobility. Although Mr J is going to sessions daily with the Occupational Therapist and Physiotherapist, he has been limited in participating to his full potential due to his pain levels. I decided that I must take action in order to try and rectify the problem.

After discussing the situation with the doctor on the ward, I am feeling very optimistic that something is going to be done. On returning to the ward the following day, I found Mr J in high spirits. He had a restful night's sleep and is not experiencing any pain in his knees. Mr J participated fully with all his cares this morning and appeared to be walking better and without pain. The panadeine which the doctor has prescribed seems to have been effective.

Reflection

I am pleased that I was able to assist Mr J in obtaining relief for his pain. This unfortunately proved to be a temporary measure. I am however regretful that I did not interpret his pain level sooner and that when I did I was reluctant to discuss this with the doctor. I assumed that Mr J was receiving the most appropriate medication related to his pain level. In the future I will not just take for granted that a client's pain needs are being met. Everyone has different levels of pain and what might be appropriate for one client may not necessarily be for another. I have learnt that in order to practise effectively I must also learn to trust my own judgements, particularly when I become familiar with my clients limitations.

Summary

Sharing my journal writings and relating them to Benner's (1984) helping role has been an enjoyable and rewarding experience. I have examined my journal entries and gained valuable insight about my practices in clinical. Everything I have learnt through my journaling has contributed to the way in which I care for my clients and given me a better understanding of Benner's (1984) concept of care.

The exemplars that I have written reflect how I, as a nursing student, am endeavouring to treat my clients holistically. By reflecting and analysing my journal entries I have been made aware that there is always room for improvement, and by documenting these experiences during clinical practice we can improve and change our nursing care for the better for our clients.

Reference

Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing practice. California: Addison-Wesley.

Exemplars from Practice

A Collection of Work

Benner Assignment 5 by Lorraine McKinnon

Introduction

Benner's (1984) theory was developed from practice with the view that theory comes out of practice. Benner's Theory - The Helping Role is broken down into eight competencies, which emerged for her as she observed nurses working with patients as well as analysing interviews she had with nurses about their care given to particular patients.

The eight competencies are:

- The Healing Relationship: Creating a Climate for and Establishing a Commitment to Healing.
- Providing Comfort Measures and Preserving Personhood in the Face of Pain and Extreme Breakdown
- Presencing: Being with a Patient
- Maximising the Patient's Participation and Control in His or Her Own Recovery.
- Interpreting Kinds of Pain and Selecting Appropriate Strategies for Pain Management and Control.
- Providing Comfort and Communication through Touch.
- Providing Emotional and Informational Support to Patients' Families.
- Guiding a Patient through Emotional and Developmental Change: Providing New Options, Closing off Old Ones: Channeling, Teaching, Mediating.

For this assignment I will include only one exemplar which includes four journal entries covering three aspects of Benner's (1984) Competencies. The first two entries fall into Benner's (1984) "Guiding a Patient through Emotional and Developmental Change".

The third journal entry comes under Benner's (1984) "Providing Comfort and Communication through Touch". The fourth entry possibly identifies with Benner's (1984) "Maximising the Patient's Participation and Control in his or her Own Recovery". As I have reflected during my journal entries, my final reflection/summary will state what nursing means for me.

EXEMPLAR

About two months ago an 82 year old woman was admitted to the hospital section of the rest home I was going to once a week as a first year student nurse. The patient who I will refer to as Mrs M appeared to be a very unhappy individual. I could understand that the transition from home life to institutional life was traumatic. If she was not rude or critical of the staff, she would be withdrawn. The staff returned her manner and of course this did not help matters. It took me no time to find out about this person. I really only needed to sit down and give her time. Initially she was reluctant to share with me but once she realised I was not moving, she talked.

GUIDING PATIENTS THROUGH EMOTIONAL AND DEVELOPMENTAL CHANGE: PROVIDING NEW OPTIONS, CLOSING OFF OLD ONES: CHANNELING, TEACHING, MEDIATING.

Benner (1984) suggests that the competency is best suited to the nurse working in the area of psychiatric illness. I believe that this competency can also apply in the care of the elderly, especially in the case of Mrs M, my patient who is going through a period of emotional and developmental change.

Firstly, she is having great difficulties adjusting to the fact that she has to be dependent on staff to meet her needs. She is also very angry, frustrated and obviously grieving.

Mrs M immigrated to New Zealand 21 years ago along with her husband. She was 61 years at that time. Her family were the main reason for settling in New Zealand. She claims she has had no regrets with this move even at her age and has never suffered from home sickness. Mrs M has multiple medical problems.

JOURNAL ENTRY - 9/10/96

My first encounter with Mrs M made me thankful that I had recently completed an assignment which had closely looked at aging from a theoretical perspective and slotting patients into the framework. I was able to understand a little where she was coming from, the anger, the frustration and grief. To have this background knowledge, the empathy and time I was able to give her and spend with her talking, listening and drawing her out I am sure helped. I knew that I had her trust and at the end of the day when she took my hand and asked me "why couldn't all the nurses be like you?" I gently told her I would be back next

week and she said, "That is too long away for me".

On reflection I can honestly say that the holistic approach to nursing was put in to practice today. When I left that hospital I knew that I could be pleased with my efforts. The confidence in caring for Mrs M's problems came from the background knowledge gained from study. Although only a tool, it helped me to communicate with her and gave me the ability to delve into areas I would not have considered before.

JOURNAL ENTRY - 16/10/96

Once again I had the time to talk to Mrs M and follow up on last week's discussion.

I am afraid she still has a lot of grief to sort out in her life and with herself, before one can see too much change. Just being a listening ear seems to be all one can do at this point. There does seem to be an improvement in her physical abilities but mentally it will take time. She apologised for grizzling about the place and how it was run. She helped me understand a little about why she was so angry. Her culture she said, is a very critical culture and people are renowned for their out spoken, abrupt style of speaking and that her language is much more expressive than English.

I told her that one of my colleagues was also from her country and I will bring her to meet you when she has a spare moment. When she came I introduced them to each other and they immediately conversed in their language so I quietly vacated the room.

On reflection I have to think it is easy to make assumptions about people, but really can I? Mrs M is from a different culture to mine. I can still believe that she has to adjust and grieve but who knows maybe her personality is such that she has complained and grizzled about everything all her life. I would like to believe that this is not so and deep in my heart I feel that given time we will see a different side to her as she overcomes this grief. I see a fine quality in her and something special about her so I will keep observing and just be there for her.

My next journal entry discusses a different approach I took with Mrs M and I feel that this falls in to Benner's (1984) competency of:

PROVIDING COMFORT AND COMMUNICATION THROUGH TOUCH.

Benner (1984, p. 63) states, "Nurses frequently use touch to provide comfort and reach out to a withdrawn, depressed patient. Often, this human warmth and contact is the only avenue of comfort and communication available."

From a nursing perspective the ability to provide human warmth by using appropriate touch can play a very important part in the patient's feelings of self-worth which in turn leads to a good general feeling of well being.

JOURNAL ENTRY - 24/10/96

I took a different approach to Mrs M. Mind you I was feeling great, exams over, stress levels lower than they had been so I suppose it was easier to execute this style of approach. I never gave her the chance to be negative. I was bubbly, jovial and hugged her a lot and kept the interactions light, using touch therapy, had her smiling and laughing a lot. It was so good to see her temporarily happy. I kept this up right until we left. On saying goodbye she took me in her arms for a huge cuddle and kissed both cheeks about three or four times while thanking me for making her day so enjoyable and that she will miss me. I wonder whether that was the right thing to do? I feel in my heart that it worked, but it did not give her a chance to get into a deep, soul searching, negative conversation or help her address some of the underlying issues that are going on for her.

My last journal entry could possible fall in to Benner's (1984):

SENSING THE PATIENT'S PARTICIPATION AND CONTROL IN HIS OR HER OWN RECOVERY

This competency entails at least two components. Sensing a patient's strength, drive, desire, and ability to improve, and mobilising these forces in the relationship between the nurse and the patient. In some cases it may also entail serving as a patient's advocate. For this last entry I see an active participation in the integration of her care requirements.

JOURNAL ENTRY - 21/11/96

Today D and I took Mrs M out from 10.30 am - 1.30 pm. We had asked her what she would like to do. Her choice was the Botanical Gardens, D had not been there either. We were blessed with a lovely warm day. Mrs M was feeling great so away we went in D's car, wheelchair, sunhat, bags, the world was our oyster. Mrs M loved the gardens and said she had not been there before. My only regret was that I did not have a camera. We talked about it and Mrs M said it would have been lovely to have a photo taken to show my husband who had not been here as well as a reminder for her forgetful moments. I could kick myself for not thinking about it. Mrs M marvelled at the size of the trees and the beautiful shrubs. We managed to take her through the hot house as well. That was really colourful, with its tropical plants. She could have stayed there longer but time was running out. We took her to a restaurant and treated her to a lovely lunch, taking into consideration that it was her main meal for the day. Time ran out so off back to the home we went. She was so happy and appreciative of all we had done for her, she told us that words in English, could not express

her gratitude and her language would be wasted on us so she kept holding our hands, kissing and hugging us instead. I enjoyed the outing as much as she did. It was a real joy to see her blissfully happy, and seeing the gardens through her eyes made it even more spectacular for me. I have to say that as a student, we are fortunate to be able to be given the opportunity to take patients out. It all helps to fulfil the role of the holistic style of nursing. I think the fact that I had input in to her care when she first arrived, could see the frustration, anger and grief she was experiencing in adjusting to her new life in the hospital and seeing the difference in her now, not just with the outing but her overall attitude I feel she has come a long way. I am so thankful I was part of her care. I know the staff have not the time to be able to do this. The patients do get outings in bus trips but the one on one in this case two on one must have been and was quite overwhelming for her. A very special day and one I will not forget too easily.

For myself in the future, I cannot see myself nursing in a hospital or other clinical settings, but out in the community where one has more autonomy to implement one's own style of care, not ruled by strict regimes but where one has the opportunity to be holistic and be able to do extra little things for one's patient. It is also lovely to see that my instincts about this special lady were correct. She has a lovely sense of humour, depth and the critical, frustrating comments about the place are not expressed anymore. She told me that she has settled in now and thanks to us much more accepting of the place. I now see evidence of her moving through the grieving process. It is so magnificent to know that Mrs M is able to enjoy aspects of her life she thought she had lost. I feel very proud of myself, that I have accomplished some happiness for this patient in her twilight years. To me, this is what holistic nursing is all about.

Reflection - Summary

As I have already partially reflected during my journal entries, I feel I would be repeating myself so I will reflect on areas that I have possibly not covered. Although I am supposed to be practising as a novice nurse, I feel my age and life experiences have given me an advantage. I have found it frustrating to work in the status of a student but I must add that I have learned a great deal about myself and caring for others. This has come about through journaling, te mara, nursing theorists and the socio political components of our degree course and the holistic approach to nursing. I also felt extreme frustration with the institution's lack of organisation and the fact that the staffing of this institution is dominated by carers who have not had the education and training that I feel is required when caring holistically for the elderly. I see that this is not entirely their fault, problems exist because of lack of direction from the registered nurses and managers. They try to do their best given their situation, but the fact is, the market driven economy dictates the kind and quality of care given to patients.

In the past nurses have allowed themselves to be oppressed and dictated to by the medical profession and its biomedical model. Hopefully the degree course in nursing will empower the nursing profession to be seen as autonomous healers within their own right. Until that occurs I do not foresee too many changes.

Reference

Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing practice. California: Addison-Wesley.

Exemplars from Practice

A Collection of Work

Benner Assignment 6 by Melanie Harding

Introduction

Nurses often are part of "the helping role" according to Benner's (1984) domains of nursing. However their work may go without recognition or they themselves are unaware of the essential role they may be playing. Benner (1984) outlines many examples of nursing practice within the helping role. I have chosen two of Benner's descriptions under "the helping role" and have written an exemplar to show the learning and understanding I have experienced in my clinical placement.

PROVIDING COMFORT MEASURES AND PRESERVING PERSONHOOD IN THE FACE OF PAIN AND EXTREME BREAKDOWN

The helping role, within the domains of nursing practice, encompasses the acknowledgement by the nurse that they and others are often helpless to sustain or prolong the life of a patient. By viewing the situation in a different light, "there is often some room to enhance the quality of life" (Benner, 1984, p. 55) even within a short period of time. While the possibility for the nurse to save the patient's life are far and beyond, he or she has the ability to promote and sustain "the patient's sense of personhood, meaning and dignity" (Benner, 1984, p. 56). Benner (1984) suggests that the nurse must make a transition from "doing for" and "curing" the patient, to fostering comfort and support for both patient and family.

In the following exemplar, I will describe a situation in which initially I felt very negative, partly because I wasn't "doing" for the patient. On the realisation, that I was actually preserving a patient's personhood, the negative situation transformed into a positive one.

EXEMPLAR 1

Prior to lunch, I was asked by a nurse to sit and keep a watchful eye on a patient, as he had a tendency to become disorientated and wander. To begin with, I felt angry and "used" having been given a boring and mindless job by a registered nurse. The patient was hard of hearing, so a white-board and marker pen was used as a means of communication. This enabled me to introduce myself, which I was acknowledged with a smile and a nod, making me feel accepted. I had to smile when the patient drifted off to sleep, as I began to write something else. Sitting beside him for three-quarters of an hour gave me plenty of time to reflect and consider my thoughts and feelings. I remembered back to a video I had viewed which had had a great impact on me, concerning the restraint of elderly who wandered, so as not to harm themselves. Now I realised that by sitting with this patient, I was giving him the freedom to walk around, or sit or go to the toilet without being restrained. I would much rather sit with this man than see him tied in a chair with the loss of personhood, dignity and human rights. The more I watched him the more calm he made me, as he lay peacefully breathing. Although the patient may have been unaware, having the need to be with him, allowed me to change my emotions from anger to tranquillity and a negative situation to a positive experience. For me, a mindless job had turned to one of accomplishment.

PRESENCING: BEING WITH A PATIENT

Nurses have often been trained in the understanding that they are most effective and efficient when "doing" for a patient (Benner, 1984). Although "just being" with a person may appear worthless, in many instances this interaction is an essential priority. While it is not necessary to offer a solution for the person it may be important to "allow patients to ventilate their feelings often without speaking at all themselves" (Benner, 1984, p. 58). The contact between nurse and patient and the building of rapport can be enhanced through various uses of touch.

The following exemplar outlines my patient and the situation I placed myself in, a great learning curve. E, suffering from peripheral vascular disease at the age of sixty-eight, has recently had a toe amputated. In the previous nine months, she has suffered great losses in her life following a stroke. This has caused blindness and progressive cognitive impairment.

EXEMPLAR 2

On arrival to the ward, I found E in a very weary and distressed state. When I see a person cry, in my eyes, the pain must be deep, whether it be physical or emotional. My initial reaction was to reach for her hand and question what was wrong. Tears welled up. Crying, she explained "I just want to go home, I'm just sick of everything". From my past experience, allowing the person to talk and enabling them to express feelings rather than letting them build up, helps ease distress. I was quite proud of my "open questions" by asking, "how do you feel?" and "why do you think you feel this way?" I was quite concerned, however, I viewed her crying as beneficial, so allowed her to continue. Progressively she became more tearful, distressed and even began shaking. I now realise I played the part of a sympathetic person rather than an empathetic one, and

thus allowed E to become non-functional. In the mean time, my buddy nurse and tutor had observed the situation and its progression. Finally after half an hour, my buddy nurse came bouncing up, throwing her arms around E's shoulders and asked, "what's the story with all of these tears?" E began sobbing even more. My buddy continued with "are you still in bed, I think it's time we got you up". Initially I thought, she's being pretty abrupt and doesn't she understand she's not happy. Who cares about getting up early, isn't letting her talk more important? My buddy took me from the room and kindly explained that sympathy was what she didn't need.

It had been fine to give tender loving care but by giving her too much sympathy she had become non-functional. I had churned up her emotions too much. She explained it is one thing you learn with experience, the balance of sympathy and getting on with tasks, for it to be therapeutic. I now understand I moved out of the therapeutic zone to it being harmful for E. On returning to E, even my voice had changed to become louder and more positive. To my surprise her tears subsided. Together we got on with the tasks that needed to be done. Progressively she became chirpier and even appeared positive. In the afternoon we walked round the garden something she has always declined doing.

Conclusion

Within the domains of nursing, the helping role, as outlined by Benner (1984), can easily go without recognition by both patient and nurse. Through journaling and reflection, it has allowed me to draw from examples from my practice to explain the helping role. In both exemplars, I learnt, that as part of the helping role, the emphasis is not placed on doing for and curing the patient, instead it is often just being there.

Reference

Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing practice. California: Addison-Wesley.

Exemplars from Practice

A Collection of Work

Benner Assignment 7 by Felicity McIntyre

Benner's theory (1984) known as The Helping Role is broken down into eight competencies which became apparent as she watched and evaluated nurses working in clinical settings. She also asked nurses to discuss in detail the patient care they were involved in with their assigned patients. The competencies are as follows:

- The healing relationship: Creating a climate for and establishing a commitment to healing.
- Providing comfort measures and preserving personhood in the face of pain and extreme breakdown.
- Presencing: Being with a patient.
- Maximising the patient's participation and control in his or her own recovery.
- Interpreting kinds of pain and selecting appropriate strategies for pain management and control.
- Providing comfort and communication through touch.
- Providing emotional and informational support to patients' families.
- Guiding a patient through emotional and developmental change: Providing new options, closing off old ones: Channelling, teaching, mediating.
- Acting as a psychological and cultural mediator.
- Using goals therapeutically.
- Working to build and maintain a therapeutic community.

Introduction

Within this assignment I will elaborate on two of the competencies described by Benner (1984), the first, "Presencing: Being with a patient" followed by "Providing comfort and communication through touch". Sharing how I have become involved with each during my clinical placement experiences, my feelings and interpretations as I see it, of the situations.

EXEMPLAR ONE - PRESENCING: BEING WITH A PATIENT

Nurse training in the past has placed an emphasis on the profession of nurses only being effective when doing things for the client. Benner's (1984) theory now suggests that nursing for the future places more emphasis on the ability of the nurse to assess what the client's needs are. This could include either doing things for the client or being present with the client, providing comfort and giving them the opportunity to express their susceptibilities or concerns on the understanding that they will not be judged or persecuted by the nurse. This has the potential to aid the client in their recovery, self-esteem and self-worth.

"Specific actions such as eye contact, body language and tone of voice are indications of caring as perceived by patients. These actions take no additional time and yet make a difference in patient well being" (Simons, 1987, as cited in Benner & Wrubel, 1989, p. 13).

The first exemplar that I will discuss is centred around my patient who I will refer to as Mrs C. Mrs C is ninety years old and her condition presents that of dementia probably multi-infarct type. She is completely dependent on her caregivers to maintain her activities of daily living and social interaction. Mrs C is immobile and is unable to converse with me, however I do believe she can hear my voice and has some understanding when spoken too.

WEDNESDAY 21.8.96

My involvement with Mrs C began today, the first lunch time in the hospital. I never thought that feeding someone could be as saddening as this felt. Mrs C was completely dependent on me. She had no ability to converse with me, which was an immediate barrier that I had to overcome. I didn't know where to begin, how she was going to indicate if she enjoyed her lunch or whether I was feeding too fast or too slow. Was I going to be able to pick up her signs accurately? I found this very difficult and thought constantly of ways to improve the situation. I was so nervous I couldn't come up with a solution. I tried to put myself in her situation but I just couldn't comprehend what it would be like. I knew she could hear me and see me but she was just unable to respond. When she could she smiled and this made me feel as though things were going okay. I wanted to let her know she could trust me so I kept smiling and making light conversation. I hope to be able to get to understand Mrs C more and perhaps pick up on some of her reactions to draw some conclusions about what she likes and dislikes.

My Reflection

During this time spent with Mrs C I was very nervous and unsure of how to approach her. I felt as though she could sense this through the course of our interaction. I knew this was going to be difficult, as I had never had any involvement with someone so utterly dependent on someone else. I tried to make conversation but I felt it was just small talk which had little relevance to anything and was a waste of time. I initially thought why couldn't I be assigned to a patient who is able to talk. When reflecting upon this I realised it was a challenge, a personal challenge for me to learn to understand different forms of communication. I can honestly say I thought I was there to complete tasks. It was at this moment that I noticed perhaps the interaction we shared meant more to Mrs C as her life was deprived of the normal conversation and contact we would take for granted. I did not understand the way I do now the importance of just spending time sitting near someone providing some form of stimulation as being beneficial. There may not be any physical signs of improvement but some form of development may have been gained mentally like increased self-esteem.

As a student nurse I have appreciated and utilised the fact that I have been lucky enough to have the time to spend interacting with Mrs C. From this I have been able to implement some techniques of nursing care that fall into the holistic style of nursing, seeing the client as a whole person rather than individual segments. By achieving this early in my education it leaves me plenty of time to develop my wisdom in this aspect of care.

Although this style of nursing is the ideal for the patient involved I can also see within the clinical placement we are situated it is not always obtainable as the clinical settings are understaffed. By this I mean fewer registered nurses are employed and staff consists more of carers who have not had the extensive educational opportunities. Because of this I believe they are unable to apply the skills we are currently developing from this course. The importance of such invisible and unarticulated care is what makes nursing special for me and how building a therapeutic relationship is within grasp with whoever you are providing care for. All these factors contribute to learning more about what it means to be a nurse for me. I will always look further than the physical ailments and aim to care for my patients holistically.

EXEMPLAR TWO - PROVIDING COMFORT AND COMMUNICATION THROUGH TOUCH

Nursing is a profession that brings nurses and patients into mutual contact. This can bring into light tender or painful feelings and provide relief from pain. The ability of a nurse to provide human warmth and empathy through suitable touch can hold the key in emphasizing the client's feelings of self-worth and improving their entire health status. Benner (1984, p. 63) states "nurses frequently use touch to provide comfort and reach out to a withdrawn, depressed patient. Often this human warmth and contact is the only avenue of comfort and communication available". She goes on to say "a touch conveys rational and support messages as well as physical stimulation and comfort. It is perhaps symbolic of the direct laying on of hands, so central to nursing care" (Benner, 1984, p. 64).

The second exemplar is about my interaction with another patient under my care, who I will refer to as Mrs M. Mrs M is an elderly lady, very hard of hearing and is suffering from several medical conditions, including cancer. She was diagnosed as having only six months to live and has outlasted this given period by several months.

FRIDAY 22.11.96

Lunch was over by the time I returned to help Mrs M back to bed for the afternoon. Instantly within her face I could see an expression of pain hiding behind her small smile. When I removed her shoes it was obvious that some of her pain was centred around her feet. They were very swollen and discoloured purple. I asked if her feet hurt, she replied "yes dear". The registered nurse confirmed our suspicion of poor circulation and perhaps a possible side effect of her current medication. I sat with Mrs M for a while gently rubbing and massaging her feet. They were very dry along with her lower legs so I applied some BK lotion. She commented how lovely it felt and how her feet felt better. As she said this I thought to myself, six months ago I would never have touched someone's feet let alone massage them. But today I hadn't even given it a second thought, I just did it. The expression on her face said it all and I understood at that moment the power of therapeutic touch and its importance in nursing. Not only was touching her feet uplifting her spirits it was also showing the benefits by restoring her feet back to a healthy colour. At various intervals she closed her eyes with a smile still visible on her pained face and quietly whispered the words "thank you". I could see she was tiring and the blankets were drawn down so she was probably feeling the cold by this stage also. I gently placed her feet under the covers and pulled them up. As I went around the side of the bed to lift the rails she clasped my hand and drew me close, thanked me again and kissed my hand. Her hands were extremely cold but I could still feel the warmth of her heart. This was very touching and I wanted to leave her as comfortable and safe as I could. I lifted the rails and slipped away. I returned a short while later with a warm wheat pack for her to clasp during her afternoon nap. The smile and look in her eyes was all she needed to share with me to show her gratitude. I didn't need her thanks to make me feel good about what I had done for her, I just needed that small indication that she was happy. I look forward to spending my remaining week with Mrs M and I love being involved in her care.

After spending this special moment with Mrs M it was kind of disappointing to hear the staff comment of "where are you taking that wheat pack". When I replied "to Mrs M as she has cold hands", they said, "well she's never needed it before". Before I could stop myself I just said, "well she does now" and left it at that.

My Reflection

The interaction that Mrs M and I were involved in was beneficial for both of us in various ways. For Mrs M it was comforting, relieving her pain and improving her present condition. She was becoming relaxed and I could sense how she was feeling without her having to say, simply by her body language and expressions. I didn't need to talk as my hands had taken that role over as they rubbed and massaged her aching feet. Through these actions I was displaying, I was showing Mrs M that I had an interest in making her more comfortable and I was taking time to interact one to one which I would call a form of personal, individual care which can develop very special moments. It is also a vital measure in order to create a therapeutic relationship.

As a student nurse I felt I had the power to provide Mrs M with a wheat pack for her cold hands brushing aside the comments from staff. It had never been identified as an intervention with in Mrs M's care but I saw fit for it to be implemented for this particular situation. When questioned, "since when does she need a wheat pack she's never needed one before", I felt I didn't need to give an explanation or justify why so I just stated "well she does now".

Through this involvement I can clearly see my progress from a novice to advanced beginner. I understand my intuition to be important enough to take action upon but at times still need a prompt or assistance from my tutor. I believe it is more worthwhile making someone in pain feel safe and realise that their nurse is there to reach out to if they need, providing them with support and an ear to listen. This is much better than leaving them to lie alone simply because now is when they usually have an afternoon rest.

Six months ago I would never have touched someone's feet, especially a stranger. Since nursing however I have no real fears about the human body and its functioning. If I feel a measure needs to be taken, then I shall do it as it will help me to grow and learn about the way I carry out my practice as well as the patients under my care. I enjoy reflecting and hope to write about a lot of memories I will cherish in years to come.

Conclusion

From looking over the journal entries that I have written during this year I realise that there is a lot that can be missed by taking every day actions for granted. The tone of your voice, the moments that you smile are all significant factors that come without any extra effort. I personally smile a lot but when I'm not smiling I can look very serious and often concerned, and this may concern a patient. I thought sitting with someone just holding their hand was not achieving. I now no longer feel this way and that makes me feel good about me. From now on in my practice I will pay much more attention to all the small factors associated with healthy caring practice, as they could be the most important.

References

Benner, P. (1984). From novice to expert; Excellence and power in clinical nursing practice. California: Addison-Wesley.

Benner, P., & Wrubel, J. (1989). The primacy of caring. California: Addison-Wesley

Exemplars from Practice

A Collection of Work

Benner Assignment 8 by Sam Finch

Introduction

The following essay has evolved through examining the prominent nursing theorist, P. Benner, and in particular "The Helping Role", which she describes in chapter 4 of her book "From Novice to Expert : Excellence and Power in Clinical Nursing Practice".

In this chapter, Benner (1984), has introduced and explained the term "Helping" and how it can be applied to many different contexts which a nurse may encounter throughout their career.

Specific entries from my own personal nursing journal have been selected and rewritten as exemplars, in order to illustrate my level of nursing practice and how this fits within two major aspects of Benner's (1984) "Helping Role"; Presencing : Being with a patient and Providing comfort and communication through touch.

The "Helping Role" has been broken down into eight separate parts or "competencies" which have each emerged through the author's observations and interviews, of various nursing settings and experiences.

In one of these competencies, Benner (1984) discusses with her reader the concept of: Presencing : Being with a Patient.

In this Benner explains that in many situations nurses have the essential importance of simply being with a patient, rather than doing for the patient (Benner, 1984). In my first year of nurse training, I have identified on several occasions how important simply spending time with a patient is. Whether it be an informative talk, a friendly chat, or perhaps just being available to listen, or, on some occasions merely sitting aside someone in silence. I believe that all of these aspects of presencing, are invaluable and very powerful moments experienced by the nurse, just as much as by their patient.

EXEMPLAR I - 1.8.96

On meeting Mrs R I was initially quite shocked by her excessively tiny frame as well as her rather abrupt manner. As I entered the room, I was not welcomed with a pleasant smile or "good morning", but instead with a scowl and shout of outrage because of her desire to return to her own home. This behaviour immediately made me feel very incapable and awkward and these feelings were intensified by the fact that Mrs R was nearly totally deaf making communication between us rather difficult. I spent quite some time trying to be of some sort of comfort or reassurance however I'm not sure exactly how much of it she actually heard. I realised quickly that Mrs R was a very lonely, miserable elderly woman who had many feelings of rejection and abuse by her family situation. I was keen to make a difference for Mrs R on this one day, yet because she was largely deaf and couldn't appear to lip read I found communicating and comforting very stressful and difficult.

I suggested to my buddy, and as much as I could to Mrs R that I took her for a walk around the hospital grounds. I hoped it might cheer her up to see the sun and feel the fresh air, however I became more worried that I had just made her feel excessively cold more than anything. I wheeled her back into the ward worried at how she was feeling and going to respond. When we reached her bed, she took my hand and told me that it was the nicest thing anyone had done for her in a very long time. It made me both sad and happy that something so little had meant so much to her.

EXEMPLAR II - 10.10.96

It was a quiet day on the ward which enabled me some extra time to spend with Mrs B. Initially I began our conversation by trying to obtain information about her health deviations, so as to successfully complete an Orem assessment for the day. Yet as our conversation developed she started talking with me about her emotional state of mind as well. She told me how very depressed she had become and how fed up with her life she was after five months in hospital. She told me she just felt like "giving it all up". This came as a shock to me, as I had always viewed Mrs B as such a determined woman, however when I put myself in her position the feelings of helplessness and anger that she expressed were so very understandable.

Mrs B told me that she was not expecting to be able to ever walk again or resume many of her past interests. She was in the process of teaching herself to write with her left hand though she even felt like giving that up as it had become very frustrating and tiring for her. As she talked I sat there on her bed with her hand clutching mine. I felt so helpless and powerless. I couldn't find any appropriate words to encourage or comfort her. I just hoped that being there to listen and giving her the time to express this mixture of feelings had helped in some way. What can I say in such a situation? When I'm sitting there so young and healthy with the world at my feet, nursing someone who is no longer able to function with the right side of her whole body.

Insights and Reflections

Both of the examples appeared initially to be such insignificant and minor details, yet reflecting on both exemplars has enabled me to realise how beneficial comforting and empowering these experiences were to the patients involved as well as myself. I believe that by simply being there provided comfort for the patients allowing them to discuss their mixture of feelings and fears, and know that they are being listened to genuinely by someone who is removed enough from the situation not to criticise, or judge, but simply listen and support and be there to embrace or cry with.

Benner also deals with the issue of: Providing comfort and communication through touch.

Benner (1984) has observed that nurses very frequently use the simple form of touch as a means of providing comfort and developing some form of relationship or bond with their patients. I felt that this aspect of "The Helping Role" exposed many similar experiences as the concept of presence dealt with previously. "Touch conveys relational and support messages as well as physical stimulation and comfort" (Benner, 1984, p. 64).

I believe that through simply giving someone a hug, by holding their hand, or maybe just giving them a pat on the back, can convey a variety of messages and feelings.

I have learnt through my little experience that the simple "laying on of one's hands" provides a means of communication as well as comfort, reassurance and release for a patient, friend, relation or even colleague, at a time when maybe words are not needed. I realise, however that touch is not always considered appropriate and should be thought about, and permission should be received before proceeding so as not to offend or send wrong signals to the person.

EXEMPLAR I - 19.4.96

I worked on building up a good rapport with Mrs J and felt that she was beginning to feel more comfortable with the situation. We talked about her family and interests as well as the reasons why she was in hospital.

At first I tried to incorporate as many of the client assessment questions into our conversation yet soon realised that perhaps this wasn't always possible or necessary for a successful interview. The aspect which struck me most was Mrs J's intense loneliness and the guilt that she described as she felt so dependent on her two children. I felt sad, partly because I couldn't find a comforting solution and also because I just couldn't imagine how it must feel to be trapped in such a broken down and frail body, yet with such an active mind. As she talked with me and told me how she felt lonely and depressed with herself I held out my hand to her and gave her a gentle squeeze. I believe that she appreciated this simple means of comfort as she gave me a little squeeze back.

EXEMPLAR II - 31.5.96

M suggested I took Mr C for a shower, shave, etc. I concentrated on getting a grip on my fears and took the attitude that "there is a first time for everything". I felt nervous. I let Mr C in on a secret that it was the first time that I had showered somebody and he was very reassuring. As Mr C had quite acute parkinsons disease he required quite a lot of assistance in the shower. I soaped up the flannel and washed his back, legs and hair, and tried to encourage him to do as much for himself as possible. I spent quite a long time in the shower trying to be as thorough as possible.

Mr C appeared to be so pleased with the experience he thanked me profusely for the "lovely back scrub" and hair wash, which helped me to feel so much calmer and more confident with the situation, and I assume it made him feel pretty good too.

Insights and Reflections

These scenarios are just two of many similar experiences which I have encountered in my first year of nurse training. I do believe that every situation is slightly different from the last and I think that there is something new to be learnt from each.

In exemplar one, I felt that I used the power of touch to comfort my patient at a time when she felt she had nothing to strive for and not many people to turn to. Reflecting on this seven months later I can recall feeling so helpless yet, I believe now that Mrs J. was not searching for any answers, but simply someone to stop, spend some time with her, let her talk and most importantly listen to her.

In comparison to this exemplar, is my second experience (exemplar II) which I feel that I made use of touch in a way to meet the patient's needs, as well as to overcome my own fears. Through taking my time and carefully and thoroughly giving Mr C a good shower, I was able to overcome my own nervousness of washing a naked and elderly man, as well as offering a pleasant and comforting experience for the patient.

Conclusion

I have found through discussing and evaluating the four exemplars previously submitted to be a very valuable experience, both educationally and mentally. This process has identified simple but effective skills that I was unaware I possessed and which I have since learnt are both beneficial and empowering to make use of throughout a nurse's career. I am now aware of why there is considerable encouragement for us to

maintain a weekly journal.

Reference

Benner, P. (1984). From novice to expert : Excellence and power in clinical nursing practice. California: Addison-Wesley.

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Exemplars from Practice

A Collection of Work

Benner Assignment 9 by Jane McDonald

Introduction

This essay sets out to look at how by journalling and reflecting on each clinical experience our knowledge expands and develops. Patricia Benner's (1984) theory, which will be briefly outlined, requires that we acknowledge that theory comes out of practice. Four exemplars related to my clinical practice and journalling are described against two competencies which illustrate my progression and development.

The Theory: Novice to Expert

Benner based her theory on a skill acquisition model developed by Hubert and Stewart Dreyfus (a philosopher and mathematician respectively). This model claims that to acquire development of skill a student passes through five levels; -novice, advanced beginner, competent, proficient and expert. Within the framework of this theory lies seven domains of practice, each domain containing competencies which describe knowledge embedded in clinical practice (Benner, 1984).

Benner (1984) postulates that over time nurses gather clinical knowledge but lose sight of what they have learned. By journalling and reflecting on the entries made, using Benner's (1984) theory it is possible to recognise the passage through the various levels of expertise. I have chosen four entries from my journal to illustrate my progress through the previous six months. These exemplars relate to the "Helping Role" as described by Benner.

The Helping Role

Benner (1984) believes that by caring nurses can establish a condition of trust where help can be given and received. Within this domain lie eight competencies and my first exemplar relates to:

Guiding patients through emotional and developmental change: Providing new options, closing off old ones; channeling, teaching, mediating.

Although Benner relates this competency largely to the psychiatric nurse, in many ways it seemed relevant to a situation where I was caring for an elderly confused client in a rest home. Mrs E is 96 years of age, has restricted mobility but can walk with the aid of a frame, is hard of hearing and sometimes confused. This can make her appear belligerent. However, she has a quick wit, a wonderful imperious manner and is often right up there with the play.

My first journal entry regarding Mrs E shows how I felt totally at a loss to understand her needs or moods. I felt I was there purely as a spectator, holding the safety net but not able to give guidance or pre-empt her thoughts or actions.

EXEMPLAR 1 7.6.96

Mrs E was propped up on her pillows with her eyes half shut, her stillness frightened me. We asked if she was ready to get up, she didn't stir. L and I thought that maybe she was dying so we set off for help. The aids assured us that this was normal for Mrs E in the mornings and not to worry. We woke Mrs E and I went off to fetch bed linen. I helped Mrs E to the toilet. I thought she could collapse on me and I wouldn't know what to do. She didn't want to go to the chapel and then she changed her mind. It was panic stations to get her ready in time.

5 months later & ...

7.11.96

Mrs E was confused. She was looking for room 216 which doesn't exist in the rest home. I felt this probably related to a room elsewhere. She was worried, confused and agitated. I tried to persuade her that her room was down the corridor but she wasn't prepared to walk there and see. "They've all shown me the room and it's not mine, mine has a felt mat at the door". I tried to think of something that would reconnect her to the room and remembered a black and white photograph on the shelf of an elderly woman in a wheelchair. I knew from previous chats with Mrs E that she had a real love for her mother and I said, "there's a photo of your mum in your room". Her voice softened and she said, "darling mum, are you sure?". "Come and look" I replied "you can tell me all about it."

Mrs E and I walked together, slowly to her room. She still didn't recognise it as hers but said, where's the photograph? I took it down from the shelf and Mrs E and I sat looking at the face smiling back up at us. "Darling mum", she said "she'd got a new hat on, she'd gone shopping and was very pleased with herself". I stayed and listened for a while as she spoke about her family and days gone by. When I felt she appeared

calm and reoriented I said that I had to go and was she feeling okay? Mrs E smiled at me and in her most regal voice said, "thank you my dear, you've been most kind, and a great help". Although I wasn't exactly sure what Mrs E meant by those words I hope it related to the fact that she'd moved from a place of confusion, to one of warm fond memories and safety.

When I reflect on my journal entries, in relation to Benner's (1984) theory, I believe I've progressed from only being able to react to situations and feeling unsure on every level through to anticipating a reaction and developing a situation which would benefit the client. I began to understand the meaning of a situation and was able to channel E's thoughts so that she was able to return to the present.

My next exemplar refers to:

Presencing: Being with a patient

Orientation towards tasks may have been the style of nursing many years ago but now health professionals are being encouraged to value the importance of being with a patient. Benner (1984) noted that several nurses she interviewed recognised this component of nursing. These two exemplars illustrate how I have learnt the importance of being there.

31.7.96

I have a problem with this feeling of invading someone's privacy, someone's space, someone's independence. Right now everything must be consciously thought about; which flannel to use, how to make a bed, what to do with the soap. It's like learning how to drive a car, nothing comes automatically.

2 months later & ..

12.9.96

A row of fall out chairs along the wall. I was walking past with fresh bed linen in my arms. A gentleman, L, caught my attention. I didn't really know him. He is thin and bony and sits quietly in his chair. Occasionally I'll catch his eyes, or his will catch mine, and they'll light up. There is humour in his face. Today he attempted to speak when I walked past. I didn't understand but I stopped to find out what he was trying to say. With difficulty I began to understand that he needed to go to the toilet. I didn't know his care needs so I told him I would go for help and return. I came back moments later with an aid who informed me that Mr L had a uridome connected and therefore didn't need toileting. She patted L's shoulder and repeated to Mr L what she'd told me and then left. L's face contorted with anguish and he obviously felt distressed by this. I didn't feel able to walk away and leave Mr L so I crouched beside him and stroked his hand. He turned his head towards me and we sat looking at each other. I reiterated that it is ok and continued to stroke his hand. Mr L's face showed me he was much pained by his circumstances. He was silently sobbing and his body was tense. I just kept looking in his eyes and saying it's okay I understand; it's okay, I understand. We sat like this for some minutes until the dilemma for him was passed. Mr L began to relax. I broke our gaze and looked out of the window, "look" I said, "the birds are trying to find worms". Mr L smiled at me. "I have to go now Mr L," I said. "Thank you" he replied.

These two examples illustrate how in a short time I learnt the value of just being there. In the first exemplar, not only did intimacy concern me but also I was absorbed by tasks which seemed dauntingly complicated. In the second exemplar the task at hand was without a thought given second priority, and I had the confidence to see the value of my presence for my patient.

Conclusion

Journalling and the writing of exemplars helps to illustrate the significance of nursing practice. By referencing Benner's (1984) theory, and applying her levels of expertise, it is encouraging to see how progress is being made. Nursing often appears to have less to do with technological know-how and more to do with intuition based on knowledge and experience.

Reference

Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing practice. California: Addison-Wesley Incorporated.

Exemplars from Practice

A Collection of Work

Benner Assignment 10 by Jo McDonald

Introduction

The following assignment includes a brief introduction to Patricia Benner (1984) and her theory including a brief explanation of the 5 levels of proficiency and the domains of nursing practice and associated competencies. The exemplars included are taken from entries made in my personal journal and relate to 2 of the competencies uncovered within the helping role, as defined by Benner (1984). The insights and reflections illustrate a link between theory and practice.

From Novice to Expert Patricia Benner (1984)

In her book, Patricia Benner (1984) uncovered a wealth of knowledge and expertise which has been embedded in nursing practice. "The knowledge embedded in this clinical expertise is central to the advancement of nursing practice and the development of nursing science" (Benner, 1984, p. 3). This knowledge has not been well documented throughout the history of nursing, but by analysing the observations made by nurses in actual practice, Benner has uncovered much of this knowledge and expertise. From this information "we learn what expert nurses do in specific patient care situations and how beginners and experts do it differently" (Aydelotte, 1984, as cited in Benner, 1984). This is explained within the Dreyfus model of skill acquisition which explains that as skills are acquired and developed, a student passes through five levels of proficiency (Benner, 1984).

Level 1 Novice

Beginners who have no practical experience of real situations and so must rely on rules to guide them. These rules are limited and inflexible and they may not necessarily be relevant in real situations.

Level 2 Advanced Beginner

Has limited experience in real situations and is starting to notice some recurrent meaningful aspects of these situations, which are starting to be put into some sort of context. Even so, the advanced beginner is still reliant on rules and cannot reliably prioritise in complex situations.

Level 3 Competent

The competent nurse may have been in practice for 2 to 3 years in the same or similar situations. He/she is consciously aware of seeing actions in terms of long range goals and is able to prioritise when complex situations arise. Speed and flexibility may still be lacking. A feeling of mastery however, enables the competent nurse to manage the many possibilities which may arise within clinical nursing.

Level 4 - Proficient

Sees situations as wholes rather than in terms of aspects. The proficient nurse is able to learn from experience what type of events are typical and how to plan and modify in response to these events. He/she is also able to streamline his/her response and so is able to get directly to the region of a problem.

Level 5 - Expert

Has an enormous amount of experience and is able to intuitively grasp a situation. This allows the precise cause of a problem to be quickly found, as this nurse no longer requires the use of rules, guidelines or maxims to guide his/her work.

Domains of Nursing Practice

Nursing knowledge which has been accumulated over a period of time has not been well documented throughout history, and due to this, we have been denied access to much of the theory which has been embedded in practice (Benner, 1984). The Domains of Nursing Practice, along with their associated competencies are based on an interpretive/phenomenological approach to uncovering much of this knowledge which is specific to nursing (Benner, 1984).

In identifying these domains and competencies: "nurses were asked to describe patient care episodes in narrative form with as much detail as possible, including their intentions and interpretations of the events as well as the chronology of the action and outcomes" (Benner, 1984, p. 44).

Themes were exposed from these narratives and from here, were formed into the 7 domains of practice and their associated competencies (Benner, 1984). The 7 domains of practice are:

- The helping role
- The teaching - coaching function
- The diagnostic and patient-monitoring function
- Effective management of rapidly changing situations
- Administering and monitoring therapeutic interventions and regimens
- Monitoring and ensuring the quality of health care practices
- Organisational and work role competencies

(Benner, 1984, p. 46).

For the purpose of this paper, only the helping role will be briefly explained along with the associated competencies.

The Helping Role

Patients look to nurses for different kinds of help than they expect to receive from other helping professionals. Help seeking and help receiving are two different issues. A person can receive help without asking for it and can ask for it without being able to receive it. Even 'help' sometimes does not help. "Some individuals with a strong need for personal control may not be able to acknowledge that they need help or even that they are being helped." (Benner, 1984, p. 47).

It is very important within nursing that the type of help offered or given is congruent with the real needs of the person who is seeking or needing help. The helping role can be closely linked to the caring role and is the basis of nursing practice. Thus the nurse is able to work in partnership with the people he/she cares for and so be more aware of the needs of that person as well as any subtle changes which may occur to the condition of that person.

The following is a list of the 8 competencies that exist within the helping role (Benner, 1984):

- The healing relationship : Creating a climate for and establishing a commitment to healing.
- Providing comfort measures and preserving personhood in the face of pain and extreme breakdown.
- Presencing : Being with a patient.
- Maximising the patient's participation and control in his or her own recovery.
- Interpreting kinds of pain and selecting appropriate strategies for pain management and control.
- Providing comfort and communication through touch.
- Providing emotional and informational support to patients' families.
- Guiding patients through emotional and developmental change : Providing new options, closing off old ones : Channelling, teaching, mediating.

Exemplars which illustrate two of these competencies will follow.

EXEMPLAR FROM JOURNAL ENTRY DATED 19.6.97

Competency : Providing emotional and informational support to patients' families

Mr T called in to visit his wife today as he does everyday. Mr T is an elderly and very frail gentleman who makes a big effort to see his wife on a daily basis. This was very apparent to me today when he told me that his car had broken down and he had caught a taxi.

Mrs T is very sick and emaciated, and I don't know how much longer she has to live, so the contact with her husband is extremely important for her. I haven't had much contact with Mrs T but I was introduced to her today when I helped the RN to change a dressing on a Stage IV decubitus ulcer on her sacral area. I felt a real responsibility towards her as she lay there, hardly flinching, as though she didn't care what happened to her anymore. She seemed so helpless and I felt that there was very little I could do for her except to stroke her hand and talk to her with a gentle voice.

I was really pleased when Mr T arrived to visit his wife, as he cares so deeply for her and gives her lots of support. The sound of his voice must be a wonderful sound for her, as she visibly relaxed as he spoke. I later found out that he had cared for her all by himself during the earlier stages of her illness, at great personal sacrifice. As Mr T entered his wife's room, he immediately checked the bed only to discover that his wife's new blanket was gone. Mr T was visibly distressed at this discovery, and I was no help as I knew nothing of the blanket. At this stage I told Mr T that I would find out what had happened to the blanket.

As this issue was obviously so important to Mr T. I returned as quickly as I could to tell him that the blanket had been soiled and so had been sent to the dry cleaners as normal washing would cause it to shrink. Mr T's reaction surprised me, as I was expecting him to be quite upset that the blanket wouldn't be back for 2-3

days, but instead he said to me, "Thank you so much, thank you for coming back and for caring," and then he gave me a big hug. I knew that the blanket was very important to Mr T, but I was totally amazed and yet pleased that just knowing what was going on would make such a big difference to this gentleman's feeling of security.

On reflection, I am able to see that by caring for and meeting the needs of Mr T. I am also caring for his wife. It is very important that Mr T knows what is happening with his wife and that he knows that he too is cared for. He puts a great deal of effort into caring for his wife and being there for her and his own emotional needs may very often go unmet.

I'm glad that I was able to do something for him, albeit small, if it made his day a little brighter. (The hug and smile are my reward.)

EXEMPLAR FROM JOURNAL ENTRY DATED 30.4.97

Competency : Providing comfort and communication through touch

I had just returned from a 2 week break to discover that Mrs W had been placed in hospital care and was dying. When I first met Mrs W she was a very independent woman. Her independence was very important to her, and she had been able to look after most of her own needs in her self-contained unit. Mrs W had a mastectomy a few years earlier and subsequently developed bony metastases which eventually found its way to her brain. Mrs W's health declined very quickly at this stage, and I did not see her for some months while she was being cared for elsewhere. When she came back, it was for terminal care. The RN explained to me that Mrs W probably wouldn't be here when I returned the following week. When I found Mrs W, I was shocked by her appearance and could not believe that this was the same person I had cared for some months earlier.

At first, I didn't know what to do or say and felt very inadequate, so I asked Mrs W if she remembered me, at which she replied yes! yes! in a very quiet, croaky voice. She was obviously having difficulty communicating verbally and was unable to move very much at all. She was clutching at the bed rail as if in absolute desperation of her situation. I didn't know if she was in pain, but from previous knowledge of her, I knew that she did not like to be dependent and that must have been very frightening for her. I knew that death frightened her as she had once told me that she didn't want to think or talk about dying.

My mind was in turmoil as I struggled to think of the best way that I could help her. As I realised that there was not a lot that I could do, I just continued to sit next to her holding and stroking her hand. As I did this, Mrs W loosened her grip on the bed rail and appeared to relax a little and enjoy the massage. Mrs W died on the following Saturday.

At the time, I felt that I wasn't really doing much to make a difference for Mrs W, but on reflection I have come to realise that through touch, I was able to provide some human warmth and my feelings of caring and support were able to be conveyed without the use of words. This is an important part of the holistic nursing care which I am able to offer to my clients. I'm sure that I made a difference to the way Mrs W was feeling on this day and if I was able to help Mrs W, just a little, to experience a peaceful death, then it was worth it.

Conclusion

This assignment included a brief introduction to Patricia Benner (1984) and her theory, including a brief explanation of the 5 levels of proficiency and the domains of nursing practice and their associated competencies. The exemplars are taken from personal journal entries and discussed certain incidents which occurred while I was caring for two very special people and the way in which they related to the helping role (Benner, 1984). The insights and reflections were personal, while linking theory and practice.

Reference

Benner, P. (1984). From novice to expert : Excellence and power in clinical nursing. California: Addison-Wesley.

Exemplars from Practice

A Collection of Work

Benner Assignment 11 by Rachel Hitt

Introduction

Patricia Benner is one of many theorists in the practice of nursing. She sees nursing as containing a variety of facts which all require a wide array of skills and encompass a diverse number of approaches and outcomes. The helping role is one facet of Benner's (1984) theory that in general, describes that in many instances the nurses form of helping goes beyond the narrow sense of 'therapeutic' help. This essay outlines the helping role of Benner's (1984) theory and illustrates how my own clinical practice experiences fit within two selected aspects within this role.

Benner's Helping Role

The domain of Benner's (1984) theory she calls the 'helping role' has been broken down further into what she terms eight competencies. These competencies allow nurses specific areas for analysis which looking into their own clinical practice, to study and reflect on what exists in their own nurse-patient relationships. Of the eight areas of the 'helping role': 'presencing' and 'providing comfort measures and preserving personhood in the face of pain and extreme breakdown' are the two selected to illustrate my own nursing practice.

Presencing

The first of Benner's (1984) competencies within the 'helping role' to be used for the application of my own clinical practice, is that of 'presencing'. Benner (1984) describes presencing as the nurse seeing great importance and value *in being* with a patient rather than *doing for* the patient, such as through person-to-person contact touch or just listening. The following two exemplars are where I found presencing to be a vital part in the transmission of care.

Exemplar 1:

I had only been nursing this lady for three days but we had already built up a very trusting relationship. She was in constant fear of falling and of being hurt physically, so much so she vomited after we tried to walk her. When anyone came near her she would scream out and yell at people to stay away from her feet. After a morning of caring for her I became very aware of the need to explain to her first that I was going to move her feet or touch her legs. Every time I told her I was going near her feet I would run my hands gently down her legs and then place my fingers on the soles of her feet until she was calm and realised I was not going to grab or bump them quickly. As the day went on I carried out this routine even when I was just walking around the end of the bed to try and let her know where I was and to convince her that I was not oblivious to the potential pain I could cause if I knocked her feet.

A very distressing time came for her when she was being transferred from her bed to a trolley. There were five people assisting her as she was severely immobile. Her anxiety was increasing by the second as people got things organised and talked about the most appropriate way to move her. She started yelling about her feet. At this stage I was standing behind two nurses who were preparing themselves to transfer a leg each. I was just listening to her growing distress knowing full well that not everybody knew the extent of Mrs M's leg pain. I squeezed between everybody and placed both hands on her legs in the exact same way I had done time and again during her care. She immediately cried out and then she relaxed as I ran my hands down towards her feet. Her face changed from a crinkled ball into a peaceful gaze. I knew at that stage that she could feel that those hands belonged to me and that she knew that I wasn't going to hurt her.

Insight and Reflection

Even although I had only been caring for Mrs M for three days she obviously felt I could bring her the comfort no one else could. At the time, I felt that three days is not really a long time, but it was three days longer than any other carer had had with her. As I felt her anxiety build, I could feel my own heart rate increase and my stomach knot, and just to touch her and extend this comfort made the emotion drain and the distress decrease for both of us. To actually see the visual changes in her expression made me see that a stressful situation can be controlled and managed by simple care, and in this case, the care I showed through touch empowered Mrs M to manage her own distress.

I felt it was essential to extend this form of comfort even though I did not actually realise its impact until it was written down and I assessed and analysed my actions. I feel that I could not have reacted in the same way if there was not a genuine rapport and mutual respect between us. During this process of analysing my actions, I came to the conclusion that I did not logically comfort her in a task sense, it was more of a reflex brought about by the bond we had built up. I do not think I could have reacted more effectively if I had planned it, it wasn't calculated. It was a genuine action of compassion, which I feel went far beyond the

expected therapeutic role of a nurse. In reflection, I felt that the communication by touch said ten fold what any spoken words could do, words would not have been enough in this relationship.

Even though Benner has another competency related to touch, I feel that the essence of this exemplar lies with the presencing competency. The mere fact that by extending a touch enabled Mrs M to gain comfort by believing my presence was there.

Exemplar 2:

Mrs S was a lady who had suffered a CVA only four weeks previous and she did not have any family member in the same city as her. As the days went on I could see her becoming more and more agitated with her present living situation as she felt quite isolated and very alone.

As I approached her she gave me a cheery smile and told me she had received a letter and some photos from her daughter in Brunei. She handed me a photo and explained all the people in it and told me that she had not seen her daughter for one and a half years. For the next half an hour she showed me through the photo's. All of a sudden she grabbed my arm and just held on to it. All I did was look into her face, it didn't give me any clues to what she was thinking, her eyes just stared back at me, but her grip on my arm got stronger. In a timid voice she said "thanks, you really seemed interested". My reply was an equally timid "I am" and that's all I said. We just sat there for a little while after that not saying anything and her hand remained on my arm.

Insight and Reflection

To begin with, I felt uncomfortable and unsure in this situation as this brought about a totally different level in our relationship. I found myself no longer able to view her as a lovely lady who needed rehabilitation after a stroke. She was a mother who loved and missed her daughter and family very much, a lady with a real void hampering her wholeness. I overcame my initial fears of such a personal and intimate situation and focused greatly on giving Mrs S the attention and compassion she deserved.

In this situation, I feel that Mrs S could not have shared with me at the level she did if she did not trust me with her thoughts and feelings. Although my immediate reaction was that maybe she would have been better sharing with someone emotionally closer to her, but now I understand that at that time, I was that person. While we were sitting together in silence, I felt amazingly relaxed and very in tune with Mrs S, like some how we were attached at a higher level. I can remember how I felt so incredibly privileged that she shared this part of her life with me, I could sense her pain through our connection which saddened me.

Through analysing my journal entry I can now see that the sadness I felt for her was not pity, it was the compassion I felt for another during separation from a loved one. On reflection, this situation was a very mutual exchange, she was sharing a special part of her life with me and I was fulfilling her need of sharing about her family.

Summary

In both of these exemplars I feel that it was important for me to just trust that my presence would make a difference and trusting that my presence would supply comfort was a great learning experience. It also showed me that taking time out to spend with patients and to get to know them is an immense help when delivering care. I feel that presencing is an essential part of being able to provide for the emotional and spiritual aspect of the people in my care.

'Providing comfort measures and personhood in the face of pain and extreme breakdown'.

The second competency of Benner's helping role to be used for my own clinical application is that of providing comfort measures and preserving personhood in the face of pain and extreme breakdown. Benner (1984) describes this aspect as the nurse being able to go past the normal drive of *doing for and curing*, to a new level at which he/she can attend to an individual's personhood, by facilitating the patient's sense of comfort, meaning and dignity.

Exemplar 1:

Mrs T was a lady I cared for over a period of seven days. She had a history of CVA's, the first one at age 25 and the most recent at her present age of 68 years, which had left her with a severely weakened left sided and dysarthria. Over the time that I cared for her I learnt many things about her including how important the condition and shape of her nails were to her. One experience I had with her involved the simple task of cutting her finger nails.

She asked me at the beginning of the day if I could get someone to cut her fingernails for her as they were getting too long and beginning to annoy her. I decided it was a good chance for me to talk with her and to give her time to practice her speaking if I actually cut her nails. I also knew that she was very particular about the shape and size of her nails as this directly effected her ability to hold onto her walking frame, and this was yet another factor that lead me to the realisation that cutting her nails was not just another task for Mrs T as it helped her stay the person she has always been.

Insight and Reflection

Over the period of her care I learnt that she was extremely particular about her nails, not in a fanatical way, but just in a way that I felt made her feel good about herself, correct and whole. I strongly believe it was an essential part of her personal worth. I felt that cutting and maintaining Mrs T's nails was such a small but necessary part of her existence which enabled her to feel good about herself, and I could very much sense the importance of this to her. After I had finished Mrs T's nails I could see a marked change in her expression, posture and sociability. It gave me great insight into the multifaceted value of what could be viewed, by another, as a simple task.

On reflection, I feel it was extremely essential for me to take time to help Mrs T to meet her self image needs. One of the most important aspects of this situation I found was, that while doing this, it also enabled her the opportunity and space for expression, comfort, rapport and further relationship development. I know now that I did not ever view this as a task. It was always much more, it held meaning even although it did have a functional side, she needed this to maintain her self image.

Exemplar 2:

Mrs S. was a lady who had also suffered from a CVA with resulting left sided neglect, visual and some cognitive impairment. She was very mobile but tended to forget about her left side being of different ability to her right, so she was supervised when mobilising. On one particular warm day she had become extremely restless with being in hospital, thinking that she was perfectly all right to be at home on her own. During the course of the day she began expressing her desire to get back to her garden, saying that she spent many of her past summers outdoors and it was one of the biggest things she didn't like about being in hospital.

It was a lovely sunny afternoon when I approached Mrs S about going for a walk outside in the hospital gardens. I don't think I've ever seen such anticipation on someone's face before that. We set off and walked for about ten minutes around the flower beds, she told me all the names of the flowers as we went. On returning to the ward, she told every person we saw that she had been outside looking at the flowers. Later that day I saw her propped up at the window just gazing out in a state of peace I hadn't seen her in before. Everyday now I hear from Mrs S. and other staff that she wants me to take her for a walk outside.

Insight and Reflection

During our walk, Mrs S taught me that gardening is a very big part of her life and it is a part that she cannot continue whilst in present care. I could sense her loss of control of a greatly loved activity. As we were talking, a wave of intense empowerment made me realise what a significant need I was fulfilling for her. I could sense her change of perspective, like she had a renewed motive to grasp every strain of what she loved and let that drive her toward her wellness.

At the beginning of our walk, I was inclined to believe that the situation was more task based than personal need based, as it was meeting Mrs S's mobility needs, but it was not until we returned, and she was telling everybody about the beautiful gardens outside that it impacted fully on me how it held a very deep meaning within.

On reflection on my journal entry, I realised how my perspective had changed from a beginning level to discover how much control can be regained from what I earlier would have viewed as just a simple, pleasant walk. To give this much power and control back to Mrs S after it seemed to be taken away, I feel, is an example of an unspoken reward of nursing, a reward that cannot be matched by any material asset, only one of genuine emotional fulfilment. As a first year nursing student, I began with the perspective that my performance was measured in tasks alone, and now I know that getting to know Mrs S enabled me to take my own practice to a higher level.

Summary

From these two exemplars I learnt the important fact that the most simple things can make the biggest difference. I feel it is so easy to get carried away with the technical tasks that sometimes it would be so easy to lose sight of the individual person. To just take time out and take someone for a walk can inspire hope, or to cut someone's nails can restore their person and change their very outlook.

Conclusion

The process of journal writing provides extensive scope for learning and gives us, as nurses, the chance to reflect and develop on our transmission of care. By applying nursing practice to the helping role aspect of Benner's (1984) theory, has personally re-emphasised how important our reflections on day to day clinical experiences are. To provide a safe and personal environment for all of those we care for is an essential and critical factor of nursing, and a process that grows and develops through insight and analysis.

Reference

Benner, P. (1984). From novice to expert : Excellence and power in clinical nursing. California: Addison-Wesley.